

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10296

10313

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship		c. LENGTH OF STAY IN 1b 35 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Howard. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Friendship.		d. STREET ADDRESS Route 144		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) GEORGE M. AMOSS.			4. DATE OF DEATH Month Sept Day 14, Year 19 59			5. SEX Male		6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1882		9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		11. BIRTHPLACE (State or foreign country) Md.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal,		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no.		16. SOCIAL SECURITY NO.		
17. INFORMANT Effie L. Amoss			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) Cerebrovascular accident & left hemiplegia - 13 years			INTERVAL BETWEEN ONSET AND DEATH 6 months 13 years				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from October 2, 1946 to September 14, 1959 , that I last saw the deceased alive on September 12, 1959 , and that death occurred at 6:15 P. M. from the causes and on the date stated above.			ADDRESS (Street, city or town, state)			DATE SIGNED 9-15-59				
ACTUAL SIGNATURE Charles S. Whitaker, M.D.			PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.			Clarksville, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) Balto. Co.				
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Ekinow			ADDRESS 3617 Chestnut Ave.			24a. REC'D BY REGISTRAR DATE SEP 18 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Date of Burial	
13. Name of Physician		14. Name of Funeral Home		15. Name of Burial Place		16. Name of Undertaker	
17. Name of Coroner		18. Name of Medical Examiner		19. Name of Pathologist		20. Name of Anatomist	
21. Name of Hospital		22. Name of Clinic		23. Name of Laboratory		24. Name of Pharmacy	
25. Name of Dispensary		26. Name of Store		27. Name of Restaurant		28. Name of Bar	
29. Name of Hotel		30. Name of Motel		31. Name of Apartment		32. Name of House	
33. Name of Farm		34. Name of Ranch		35. Name of Estate		36. Name of Trust	
37. Name of Corporation		38. Name of Partnership		39. Name of Association		40. Name of Union	
41. Name of Society		42. Name of Club		43. Name of Lodge		44. Name of Order	
45. Name of Fraternity		46. Name of Sorority		47. Name of Guild		48. Name of League	
49. Name of Association		50. Name of Society		51. Name of Club		52. Name of Lodge	
53. Name of Order		54. Name of Fraternity		55. Name of Sorority		56. Name of Guild	
57. Name of League		58. Name of Association		59. Name of Society		60. Name of Club	
61. Name of Lodge		62. Name of Order		63. Name of Fraternity		64. Name of Sorority	
65. Name of Guild		66. Name of League		67. Name of Association		68. Name of Society	
69. Name of Club		70. Name of Lodge		71. Name of Order		72. Name of Fraternity	
73. Name of Sorority		74. Name of Guild		75. Name of League		76. Name of Association	
77. Name of Society		78. Name of Club		79. Name of Lodge		80. Name of Order	
81. Name of Fraternity		82. Name of Sorority		83. Name of Guild		84. Name of League	
85. Name of Association		86. Name of Society		87. Name of Club		88. Name of Lodge	
89. Name of Order		90. Name of Fraternity		91. Name of Sorority		92. Name of Guild	
93. Name of League		94. Name of Association		95. Name of Society		96. Name of Club	
97. Name of Lodge		98. Name of Order		99. Name of Fraternity		100. Name of Sorority	

10297

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Mo.		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville		c. LENGTH OF STAY IN 1b 6.5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1/2 mile west Rt 97 on Rt 144		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thurman Clyde		First Thurman		Middle DORSEY	
5. SEX M		6. COLOR OR RACE Colt		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Sept. 27, 1959		9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		11b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Mo.	
12. FATHER'S NAME Joseph Dorsey		13. MOTHER'S MAIDEN NAME Maria Prettyman		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-30-8985		17. INFORMANT Eugene Dorsey - Cooksville, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of spine, with transection of spinal cord. 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Hit by automobile, while walking on highway			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	
20f. (City or town) Cooksville		20g. (County) Howard		20h. (State) Mo.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Sept. 27, 1959			
ACTUAL SIGNATURE W. Bradley King, Jr.		EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-59		22c. NAME OF CEMETERY OR CREMATORY Bushy Park	
22d. LOCATION (City, town, or country) Cooksville, Howard, Mo.		22e. REC'D BY REGISTRAR 1 '59			
22f. REGISTRAR'S SIGNATURE Arthur S. Hume		22g. ADDRESS Cooksville, Mo.			

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 100-100000
JAN 1 1933

Howard

Age

Howard

Cochranville

Cochranville

Also record on 100-100000

Sept. 27, 1932

DECEASED

100-100000

100-100000

1

Signature of physician, with registration number.

Signature of medical examiner, with registration number.

Howard

Cochranville

Age

Whitney Lewis

Sept. 27, 1932

Howard

Sept. 27, 1932

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10315

CERTIFICATE OF DEATH

10298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer's Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>C</u> Last <u>Feely</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/1869</u> <u>90?</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>Timothy Holland</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		17. INFORMANT <u>Mrs Anna M. Luttman</u> Address <u>4001 W. Belvedere Ave</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>degener</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <u>4-30</u> , 19 <u>58</u> , to <u>9-22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-19</u> , 19 <u>59</u> , and that death occurred at <u>5:10</u> A.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		DATE SIGNED <u>9-22-59</u>
PHYSICIAN'S NAME (Type) <u>THOMAS F. HERBERT M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan Son</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

1931

PREPARED BY

REPORTED BY

DATE OF DEATH

PREPARED BY

REPORTED BY

PREPARED BY

REPORTED BY

PREPARED BY

REPORTED BY

PREPARED BY

REPORTED BY

PREPARED BY

REPORTED BY

PREPARED BY

REPORTED BY

RECEIVED

NOV 10 1931

DEPT. OF HEALTH

RECEIVED

NOV 10 1931

DEPT. OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10299

Reg. Dist. No.

10316

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Clarksville			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural - Cooksville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luther Middle (none) Last Holland				4. DATE OF DEATH Month September Day 11 Year 1959			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm labor	
10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Harriett Ann Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213 03 2037		17. INFORMANT Address Irene Wilson (sister), Clarksville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9-11-59	
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (specify) Burial		22b. DATE THEREOF 9/14/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Gregory,		22d. LOCATION (City, town, or county) (State) Cooksville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surwider				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kraus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

10317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harward</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harward</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		c. LENGTH OF STAY IN 1b <u>36 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wm.</u> Last <u>Ratliff</u>				4. DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 20, 1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>feed store</u>		11. BIRTHPLACE (State or foreign country) <u>Harward Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Ratliff</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stramberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-02-205</u>		17. INFORMANT Name <u>Everett Ratliff, Laurel, Md</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Idolo Pierandrei</u> M.D. <u>Laurel, Md</u>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>IDOLO PIERANDREI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/8/59</u>		<u>St. Marys Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Davidson, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	

2560

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10301

10318

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Rest Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last E. ELIZABETH LINTHICUM				4. DATE OF DEATH Month Day Year Sept. 24, 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellicott, Md	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Andrew Linthicum				14. MOTHER'S MAIDEN NAME Frances Gaither			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Address William Talbott, Clarksville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from March 26, 1946 , to Sept. 24, 1959 , that I last saw the deceased alive on Sept. 24, 1959 , and that death occurred at 5:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D.							
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland 9-24-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-26-59	22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE SEP 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. F...		

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Figure 2

Sept. 24, 1955

SYNOPSIS

1980

www.elsevier.com

William T. (Bob) O'Connell, Jr.

10319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marjorie R. Pausch				4. DATE OF DEATH Month Day Year Sept. 7/59 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1897	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY Hutzler Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Joseph Robinson				14. MOTHER'S MAIDEN NAME Miriam Spamer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT (SON) Fred Pausch, Route 4, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER, METASTATIC 175.0 DUE TO PRIMARY SITE, OVARIAN, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with ASCITES							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8/17 , 19 59 , to 9/7 , 19 59 , that I last saw the deceased alive on 8/31 , 19 59 , and that death occurred at 3:10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. P. WILLIAMSON E. P. WILLIAMSON M.D. 2584 EDMONDSON AVENUE BALTIMORE 28, MD.				DATE SIGNED 9/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE Sept. 10/59		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
22d. LOCATION (City, town, or county) (State) Baltimore 7, Md.				24a. REC'D BY REGISTRAR DATE SEP 11 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss				24c. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WIDE AREA

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	c. LENGTH OF STAY IN 1b 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 4411 Liberty Heights Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First David Middle Last Slote	4. DATE OF DEATH	Month 9 Day 10 Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-81 1882	9. AGE (In years last birthday) 77 7/6 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder	10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? USA
---	--	--	--

13. FATHER'S NAME Abraham	14. MOTHER'S MAIDEN NAME Goldie
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 	17. INFORMANT Esther Slote Address - same
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis (multiple) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. unknown unknown
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; gangrene right foot and leg		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-29-59 , 19 59 , to 9-10 , 19 59 , that I last saw the deceased alive on 9-10 , 19 59 , and that death occurred at 11 A.M. from the causes and on the date stated above.	
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ADDRESS (Street, city or town, state) Taylor Manor Hospital, Ellicott City, Md	DATE SIGNED
--	------------------------

ACTUAL SIGNATURE Irving J. Taylor	PHYSICIAN'S NAME (Type) Irving J. Taylor
---	--

22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 9-10-59	22c. NAME OF CEMETERY OR CREMATORY Beth David	22d. LOCATION (City, town, or county) (State) Elmout P.L. N.Y.
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23. FUNERAL DIRECTOR'S SIGNATURE Jack Rivers Inc 2100 Eutan Place	ADDRESS 	24a. REC'D BY REGISTRAR DATE SEP 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Shot - Gun		8. MANNER OF DEATH Suicide		9. PLACE OF BIRTH Macon, Georgia	
10. OCCUPATION Member of Congress		11. MARITAL STATUS Single		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS RADIATION None		20. PREVIOUS CHEMOTHERAPY None		21. PREVIOUS OTHER TREATMENT None	
22. PREVIOUS HOSPITALIZATION None		23. PREVIOUS PHYSICIAN None		24. PREVIOUS NURSE None	
25. PREVIOUS OTHER CARE None		26. PREVIOUS OTHER TREATMENT None		27. PREVIOUS OTHER CARE None	
28. PREVIOUS OTHER TREATMENT None		29. PREVIOUS OTHER CARE None		30. PREVIOUS OTHER TREATMENT None	
31. PREVIOUS OTHER CARE None		32. PREVIOUS OTHER TREATMENT None		33. PREVIOUS OTHER CARE None	
34. PREVIOUS OTHER TREATMENT None		35. PREVIOUS OTHER CARE None		36. PREVIOUS OTHER TREATMENT None	
37. PREVIOUS OTHER CARE None		38. PREVIOUS OTHER TREATMENT None		39. PREVIOUS OTHER CARE None	
40. PREVIOUS OTHER TREATMENT None		41. PREVIOUS OTHER CARE None		42. PREVIOUS OTHER TREATMENT None	
43. PREVIOUS OTHER CARE None		44. PREVIOUS OTHER TREATMENT None		45. PREVIOUS OTHER CARE None	
46. PREVIOUS OTHER TREATMENT None		47. PREVIOUS OTHER CARE None		48. PREVIOUS OTHER TREATMENT None	
49. PREVIOUS OTHER CARE None		50. PREVIOUS OTHER TREATMENT None		51. PREVIOUS OTHER CARE None	
52. PREVIOUS OTHER TREATMENT None		53. PREVIOUS OTHER CARE None		54. PREVIOUS OTHER TREATMENT None	
55. PREVIOUS OTHER CARE None		56. PREVIOUS OTHER TREATMENT None		57. PREVIOUS OTHER CARE None	
58. PREVIOUS OTHER TREATMENT None		59. PREVIOUS OTHER CARE None		60. PREVIOUS OTHER TREATMENT None	
61. PREVIOUS OTHER CARE None		62. PREVIOUS OTHER TREATMENT None		63. PREVIOUS OTHER CARE None	
64. PREVIOUS OTHER TREATMENT None		65. PREVIOUS OTHER CARE None		66. PREVIOUS OTHER TREATMENT None	
67. PREVIOUS OTHER CARE None		68. PREVIOUS OTHER TREATMENT None		69. PREVIOUS OTHER CARE None	
70. PREVIOUS OTHER TREATMENT None		71. PREVIOUS OTHER CARE None		72. PREVIOUS OTHER TREATMENT None	
73. PREVIOUS OTHER CARE None		74. PREVIOUS OTHER TREATMENT None		75. PREVIOUS OTHER CARE None	
76. PREVIOUS OTHER TREATMENT None		77. PREVIOUS OTHER CARE None		78. PREVIOUS OTHER TREATMENT None	
79. PREVIOUS OTHER CARE None		80. PREVIOUS OTHER TREATMENT None		81. PREVIOUS OTHER CARE None	
82. PREVIOUS OTHER TREATMENT None		83. PREVIOUS OTHER CARE None		84. PREVIOUS OTHER TREATMENT None	
85. PREVIOUS OTHER CARE None		86. PREVIOUS OTHER TREATMENT None		87. PREVIOUS OTHER CARE None	
88. PREVIOUS OTHER TREATMENT None		89. PREVIOUS OTHER CARE None		90. PREVIOUS OTHER TREATMENT None	
91. PREVIOUS OTHER CARE None		92. PREVIOUS OTHER TREATMENT None		93. PREVIOUS OTHER CARE None	
94. PREVIOUS OTHER TREATMENT None		95. PREVIOUS OTHER CARE None		96. PREVIOUS OTHER TREATMENT None	
97. PREVIOUS OTHER CARE None		98. PREVIOUS OTHER TREATMENT None		99. PREVIOUS OTHER CARE None	
100. PREVIOUS OTHER TREATMENT None		101. PREVIOUS OTHER CARE None		102. PREVIOUS OTHER TREATMENT None	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A NURSE AND WHEN IT IS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS NOT VALID IF IT IS NOT FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

CERTIFICATE OF DEATH

Reg. Dist. No. 10304

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND <u>MD.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montevideo Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Stonestreet</u> Last <u>Stonestreet</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8/94</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Press Operator, Continental</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Slawinski</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna Sikorska</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>218 12 0328</u>	
17. INFORMANT (daughter) <u>Mrs. Carroll E. Wilson</u>		Address <u>Montevideo Rd. Jessups, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-1-47</u> , 19 <u> </u> , to <u>9-29</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>9-27</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2065. Gilmer St.</u> DATE SIGNED <u>10.1.59</u> ACTUAL SIGNATURE <u>Nathan Racusin</u> M.D. <u>Balto 23 Md</u> PHYSICIAN'S NAME (Type) <u>NATHAN RACUSIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Pk. Dorsey, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Colleen A. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10305

10322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland		c. LENGTH OF STAY IN 1b X Clarksville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simons Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LULA Middle P Last STULL		4. DATE OF DEATH Month Sept. Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-1871
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dayton, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jesse W. Downs		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Roland Stull, Clarksville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 191.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous cell carcinoma, face DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 weeks 8 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 1946 , to Sept. 20, 1959 , that I last saw the deceased alive on Sept. 19, 1959 , and that death occurred at 9:00A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 9-20-59			
ACTUAL SIGNATURE Charles S. Whitaker M.D.		DATE SIGNED 9-20-59	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		Clarksville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-59	
22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Highland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE SEP 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur G. Kneass			

CERTIFICATE OF DEATH

10822

Howard

Howard

Howard

Clarksville

Clarksville

Stanton Insurance House

Sept. 21, 1929

MIA P. STUBB

BY

11-22-1921

White

White

10-10-28

Home

At Home

James R. Downie

Unknown

Home and Soil, Clarksville, Md.

No

Clarksville

Stanton Insurance House

Sept. 21, 1929

Sept. 21, 1929

Sept. 21, 1929

Sept. 21, 1929

Clarksville, Maryland

Clarksville, Maryland

Clarksville, Md.

Sept. 21, 1929

Sept. 21, 1929

Sept. 21, 1929

Clarksville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10306

10323

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hanover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jackson</u> Last <u>Tate</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>January 27, 1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>William Tate</u>		14. MOTHER'S MAIDEN NAME <u>Emma L. Holler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louis W. Tate</u>		Address <u>1320 Stevens Ave., Arbutus, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Hemorrhage</u> <u>810X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto - Train Collision</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:25 p.m. 9-7 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) <u>Hanover</u> (County) <u>Howard Co.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Blvd. ELK RIDGE, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Cushing L. Fennell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1914</i>		PLACE OF DEATH <i>Home</i>	
CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
CAUSE OF DEATH <i>Heart Disease</i>			
MANNER OF DEATH <i>Natural</i>			
SIGNATURE OF EXAMINER <i>John Doe</i>			
DATE <i>Jan 15 1914</i>			
PLACE <i>Baltimore</i>			
COUNTY <i>Harford</i>			
STATE <i>Md.</i>			
COUNTRY <i>U.S.A.</i>			
SIGNATURE OF DECEASED <i>John Doe</i>			
DATE <i>Jan 15 1914</i>			
PLACE <i>Baltimore</i>			
COUNTY <i>Harford</i>			
STATE <i>Md.</i>			
COUNTRY <i>U.S.A.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10307

10324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Highland c. LENGTH OF STAY IN lb 25 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural - Highland. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First GLADYS Middle MARIE Last WILSON			4. DATE OF DEATH Month Sept. Day 8, Year 19 59		
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH December 8, 1919		9. AGE (In years last birthday) yrs. 39		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Thomas Thomas		14. MOTHER'S MAIDEN NAME Lillie Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Jesse Wilson Address Highland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, right breast with meta- 170X DUE TO tases to right lung. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 7-9- 19 46 , to 9-8- 19 59 , that I last saw the deceased alive on 9-7- 19 59 , and that death occurred at 7:45 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 9-8-59 ACTUAL SIGNATURE Charles S. Whitaker M.D. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/11/59		22c. NAME OF CEMETERY OR CREMATORY Hopkins Church,	
22d. LOCATION (City, town, or county)		(State)		22d. LOCATION (City, town, or county) Highland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 14 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Evans	

